Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 176

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Curam Nua**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced inspection**
Date of inspection:	**31st August, 01st, September and 02nd September 2021**
Registration Status:	**Registered from 20th September 2020 to 20th September 2023**
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Date Report Issued:	**23rd December 2021**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration in 2020. At the time of this inspection the centre was in its first registration and in year two of the cycle. The centre was registered without attached conditions from the 20th September 2020 to 20th September 2023.

The centre was registered to provide medium term residential care for up to two children, single gender from age thirteen to seventeen years on admission. Their model of care was described as the provision of residential care for children using a '*blended theoretical and best practice approach*'. The model was underpinned by the theories and frameworks of a person-centred approach, attachment theory and attachment informed parenting, a resilience strengths-based approach and a trauma informed model of care. The engagement of children in outdoor pursuits was also a key component of the therapeutic programme of care in the centre. There was one young person in placement. During the inspection the registered proprietor wrote to the Alternative Care Inspection and Monitoring Service and requested to change the registered occupancy of the service from two young people to one young person. This was agreed at the Alternative Care Inspection and Monitoring Service registration committee on 16/09/21.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what

improvements it can make. Statements contained under each heading in this report are derived from collated evidence.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 08th of October 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The centre manager returned the report with a CAPA on the 21st of October and again on 09th of November following a requirement for further clarity from the inspection team.

The findings of this report and assessment of the submitted CAPA deemed that the centre was not in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 5, Care Practices and Operational Policies and Article 7 Staffing. As such it was the decision of the Child and Family Agency to apply the following condition to the centre's registration under Part VIII, Article 61, (6) (a) (i) of the Child Care Act 1991:

- There must be no further admissions of a young person under 18 to this centre until suitable care practices and operational policies are in place and the number, qualifications, experience, and availability of members of staff in the centre are adequate having regard to the number of children residing in the centre and the nature of their needs.

It is the decision of the Child and Family Agency to register this centre, ID Number: 176 with the above attached conditions from the 20th September 2020 to the 20th September 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection findings

Regulation 5: Care Practices and Operational Policies

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

At the time of inspection, the young person in placement was over 18 years of age. There was an agreement in place to extend this placement to focus on return to education and preparation for aftercare. Until they turned 18, care planning was in line with regulatory requirements for the young person. There was no requirement for a care plan or statutory child in care review meetings at the time of this inspection and inspectors focused on a review of placement plan and aftercare plans. These plans were detailed, up to date and in line with the identified needs throughout the placement. There was evidence that individual work and key working took place to progress the needs/goals of the plans. Progress reports were prepared and shared with key professionals including the allocated aftercare worker. Inspectors found that the plans were in line with the needs of the young person and goals which had been identified through care planning.

While aspects of placement and aftercare plans were discussed at team meetings and with staff in supervision, inspectors found a lack of recording of definitive actions arising from these forums. The key worker role was not clearly described during inspection interview by staff and a staff member in a key work role was not familiar with expectations of the role as set out in policy.

There was evidence that the young person was included in aspects of planning and that they were fully consulted about setting achievable goals. They confirmed this in interview with inspectors and told them that "*this has been their best placement in residential care and that they had come a long way*". They were happy that they were facilitated to remain in the centre until they were more prepared to leave care with the support of the team.

Inspectors found that there was information relating to communication with other professionals on file including social worker, a previously appointed guardian ad litem, juvenile liaison officer, probation officer, education co-ordinators and

the aftercare worker. Prior to the young person turning 18, significant events were sent to the supervising social work departments and there was an agreement in place with the extension of the placement that the allocated aftercare workers would continue to receive notifications.

The aftercare worker spoke with inspectors and commended the work and commitment of the team stating that the young person had made significant progress throughout the placement. They highlighted the strong relationships the young person had built with members of the team and management of the centre.

One inspector spoke with the guardian ad litem who was working with the young person for many years until they turned 18 recently. They informed inspectors that the centre was child focused, the young person had built strong relationships in the centre and reports and significant events were sent to them promptly. They stated that they advocated for the young person, there was good interagency working, and that the centre had worked with them to progress the goals of the care plan.

Inspectors found that there was timely referral to access specialist supports however, the young person had chosen not to engage when appointments became available.

Inspectors reviewed care files, daily logs and significant events and found that improvements were required in how follow up to incidents was recorded. Two incidents in particular, when the young person contacted the centre whilst out overnight did not have adequate records of the centre's response. This is discussed further under standard 5.2 of this report.

Compliance with regulations	
Regulation met	
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the key working role is clearly defined and communicated to staff.
- The registered provider must ensure that actions arising from discussions relating to placement planning in team meetings and supervision are clearly recorded and tracked.
- The registered provider must ensure adequate recording and follow up to incidents when these occur.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

At the time of inspection, inspectors did not find that strong leadership was evident at all levels or that there was a culture of learning quality and safety in the centre.

There was an organisational structure in place comprised of the proprietor/director and a small advisory board relating to finance/accounting and human resources. The intended internal management structure of the centre was comprised of a social care manager, deputy manager, social care staff and an outdoor activity worker. Three staff were assigned as social care leaders and issues in respect of staffing are discussed further in this report.

Inspectors were informed that the centre manager was in the process of leaving their post and that the director had assumed the role of person in charge until the appointment of a new social care manager. The previous manager who was on long term leave and in the process of resigning was still providing some support during the transition period. Inspectors found that this was not clearly set out and the staff interviewed were uncertain about management arrangements at the time of inspection. The director had not yet written to inform the alternative care inspection and monitoring service of the change in management and must do so without delay.

Further, inspectors reviewed a number of significant event notifications for the centre. From this review, inspectors found that the centre manager who was on extended leave from the service was receiving and returning contact from the young person. This should not occur. The young person also had personal contact details for staff members and on one occasion had been given access to a staff member's personal phone. While it is acknowledged that the young person was over 18 when this occurred, inspectors found that further work was required with some staff on professional boundaries and the oversight of this.

The director stated that a new manager had been identified and would take up post in October 2021. A person within the organisation had also recently accepted the role of governance and quality assurance officer and the terms of reference for this post was being considered at the time of inspection.

However, there was no evidence of audits by the person previously assigned to the post of quality assurance. The findings of the last inspection of this centre were that the registered proprietor was required to ensure there were oversight and governance systems in place to ensure the centre was operating in compliance with the regulations and the national standards. Inspectors found that this action had not been taken by the registered provider.

Many of the tasks of management including auditing of personnel files and devising rotas were delegated to the deputy social care manager (although not formally). This person had also been asked by senior management to commence auditing the centre based on new audit tools aligned to the National Standards for Children's Residential Centres, 2018 (HIQA) and to revise the child safeguarding statement. At the time of inspection, the deputy manager had completed an audit on standards 1.1, 1.2 and 1.3 of the national standards. While they had put considerable effort into this piece of work and the director had provided some support, inspectors found that it was not an appropriate delegation of tasks based their limited social care experience, time in post and position in the organisation. Issues relating to this are further discussed under standard 6.1.

There was a governance policy in place however this made no reference to (i) auditing (ii) oversight of care practice or (iii) compliance with regulations and national standards. Inspectors did not find that the necessary governance and oversight arrangements were in place at the time of inspection.

The centre had a placement contract in place with the Tusla's National Private Placement Team (NPPT) specific to the young person in placement. The director was liaising with this team in respect of contracting and the provision of a service level agreement. There was regular communication between the parties, and this was on-going. The NPPT was also provided with updates regarding the young person's progress in placement.

The centre had a suite of written policies and procedures to guide staff practice and the care in the centre. However, these policies were not updated in line with the National Standards for Children's Residential Centres, 2018 (HIQA).
At the time of inspection, inspectors were informed a review of the suite of policies and procedures was on-going and that it was being outsourced to a company in Northern Ireland with the input of the director. The last inspection report stated that there must be systems in place to review policies on a regular basis and ensure alignment with new and existing legislation and national policy. However, this action had not been completed by the register provider.

As noted, the last inspection report stated that there must be oversight and governance systems in place to ensure the centre was operating in compliance with the regulations and national standards. A response was provided by management in the corrective and preventative action plan (CAPA) stating that this would be completed by February 2021. Inspectors found ongoing and serious deficits relating to policies and procedures. The policies provided included outdated legislation and national standards and did not provide adequate guidance for safe and effective care.

Policies reviewed by inspectors on this inspection contained information which could lead staff to act contrary to Children First: National Guidance for the Protection and Welfare of Children, 2017. One policy stated that:

> 'A *serious complaint concerning staff, for example, an alleged abuse of a resident, will not be recorded as a complaint but rather as an untoward incident and relevant authorities i.e., placing authority, local HSE Child Care manager, Gardaí and TUSLA Monitoring Officer will be notified immediately*'.

This is not in line with the correct reporting procedure for alleged abuse and is a serious oversight.

Also, during the previous inspection of the service, the centre manager was informed that reference to the HSE and to the Monitoring officer was obsolete and must be removed.

There was little evidence of discussions relating to policies, procedures and practice at team meetings. Staff, including those appointed to senior positions in the centre were not familiar with key policies and procedures including planning, child protection, safeguarding and whistleblowing amongst others. A social care leader was not familiar with the child safeguarding statement or the role of the designated liaison person. They, and another staff member interviewed could not properly describe their roles as mandated persons and the proper reporting procedures under Children First, 2017. Staff members had completed the *Tusla E-Learning module: Introduction to Children First, 2017* however, there was no training for staff in the organisation's own safeguarding and child protection policies. The deputy manager was not fully aware of some key policies including protected disclosures. As such the centre had senior staff employed in management positions who were not in a position to properly guide and support other staff in relation to safeguarding issues should they arise.

Inspectors found deficits relating to staff induction. The induction template stated that staff should demonstrate an understanding of policies, procedures and practice. The most recent statement of purpose stated that training in all policies and procedures would be provided and would be reviewed. From inspection interviews with staff and management and a review of personnel files it was clear that the induction only involved staff being asked to read and familiarise themselves with policies and procedures. This was not supported by training or follow up to determine their awareness which inspectors found was inadequate. Some staff acknowledged that they had not properly reviewed policies. This was despite there being long periods of time when the young person was out of the centre at work or training and staff were alone in the centre. Inspectors could not find any evidence of a probation period or formal probation review/sign off on any staff file. This is not in line with best practice and must be reviewed.

Staff informed inspectors that the service director was very supportive and visited the centre and met with staff and young people. However, this was not evident across centre records.

There was some evidence of oversight of centre records by the deputy manager who commented on errors or inaccuracies. Records of internal management meetings

were limited and required further detail to evidence oversight of key areas such as learning from review of significant events, consequences and staff practice for example. Inspectors found that there were no formal records of senior management meetings discussing the operational and strategic functioning of the centre and therefore evidence of governance of the centre was lacking.

Inspectors found that oversight and governance of other aspects of the National Standards for Children's Residential Centres, 2018 (HIQA) such as professional supervision and personnel files was inadequate. Inspectors found deficits in both areas that had not been identified or addressed by senior management. There were also deficits relating to recruitment of staff which is discussed below. The director informed inspectors that a new system of oversight and self-auditing was being considered for purchase by an external company. Inspectors found that the CAPA from the previous inspection of this centre was not fully implemented.

Inspectors found the staff displayed good knowledge and understanding of the young person and were able to anticipate potential risks and put measures in place on a day-to-day basis to mitigate against the risk of harm. There were individual and key work records to evidence this. The centre had policies and procedures in place for the identification, assessment and management of risk associated with the young person's care and behaviour. A new risk management framework was in place and the deputy manager was able to describe how it worked in operation. The staff team were less clear and needed more guidance as some stated that they would not be comfortable conducting risk assessments, that it was a management function.

There was evidence that risks were being reviewed and re-rated when circumstances changed. Risks specific to the young person were held on a centre register but not contained on their individual care file. Inspectors found that some areas of risk relating to the young person such as staying in unsafe locations or the risk of physical assault on staff were not adequately risk assessed or included on centre registers and this must be reviewed. Some areas of organisational risk were not included on the corporate risk register despite being highlighted in the previous inspection of the centre. These included staff working back-to-back shifts and driving return journeys of up to 4 hours each way (starting at 4am) during these shifts to facilitate the young person's work/activities. Also, the risks associated with outdated policies and procedures were still not recorded despite being raised as an issue in the October 2020 inspection.

Inspectors found that the director who was the named person in change at the time of inspection was not aware of several issues of concern identified during the inspection process. On one occasion the young person in placement had tried to contact staff when they had chosen to stay out of the centre overnight. The young person had previously been allowed to use a staff personal phone and obtained their number. They contacted the staff on shift on this number during the night and it was not noticed until morning. The young person then made contact with the manager who was on long-term leave to confirm they were staying out. There was no record of this contact on file and the records of held in the centre did not accurately reflect what took place.

In a second instance a text message at 3am indicating some possible distress or risk was sent to staff during the night. The young person was not known to be staying in a place of safety at this time. The response from staff to the young person was not accurately recorded in centre records. The director had not been informed of the issues as part of an escalation of risk nor had they discovered the issue during their review of centre records. There was no management commentary or action relating to risk, staff phones or recording of information at the time of inspection. Inspectors did not find a review of this incident and there was no evidence of follow up with the young person when they returned. The director has since written to inspectors to detail actions taken in response to these findings.

Inspectors found that there was brief reference to significant events at team meetings but usually in the context of the layout and recording, rather than a review and analysis of the incident for learning purposes. The deputy manager had commented on significant events, but this was generally relating to the young person's behaviour.

Inspectors found that while the internal management structure was appropriate to the size and function of the centre it was not operating in a way that provided accountability in the provision of safe and effective care.

Inspectors found that in response to a previous inspection, a log was opened to ensure that there was a record of duties delegated to an appropriately qualified person. This was not being properly utilised at the time of inspection as many duties/tasks had been assigned to the newly appointed deputy manager that were not recorded. There was no place to record decisions made as required by national standards.

There was an on-call system in place to provide support and guidance out of office hours. The manager and staff reported that this worked effectively in practice.

Given the issues that have been raised in this report in relation to governance, oversight and management of the centre, inspectors found that this centre did not meet the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 5: Care practices and operational policies.

Compliance with regulations	
Regulation met	**None Identified**
Regulation not met	**Regulation 5** **Regulation 6**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed.**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 5.2.**

Actions required

- The registered provider must ensure that there are oversight and governance systems in place to ensure the centre is operating in compliance with the regulations and the national standards.
- The registered provider must ensure that all policies and procedures are up to date and relevant to legislation and national standards.
- The registered provider must ensure that all staff are familiar with policies, procedures, legislation and national standards.
- The registered provider must ensure that staff are subject to a probation period with formal review and sign off.
- The registered provider must ensure that fit for purpose audits take place to assess compliance with legislation and national standards.
- The registered provider must ensure that all actions plans agreed from ACIMS inspection reports are implemented as a matter of priority.
- The registered provider must ensure that senior management meetings are recorded and there is evidence of robust governance of the centre.

- The registered provider must ensure that training is provided in the risk management framework to ensure that all staff are competent and confident in its use.
- The registered provider must ensure that all records in the centre are accurate and correctly reflect staff actions.
- The registered provider must ensure that the support provided to the young person by a previous manager of the service is structured and agreed with the Child and Family Agency, Tusla.
- The registered provider must ensure that all corporate and centre risks are recorded on risk registers, that mitigation strategies are in place and that risks are monitored on an on-going basis.
- The registered provider must ensure that there is a record of all tasks delegated to appropriately qualified staff members as well as a record of key decisions.

Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Staff recruitment and retention was the responsibility of registered provider/director of care in the organisation. As there were no formal records of meetings between senior managers in the organisation there was a lack of evidence of discussion relating to workforce planning at that level.

A sample of personnel files reviewed by the inspectors found issues in respect of recruitment and vetting. A review of a sample of interview notes for staff recruitment found that staff were scored highly at interview in fields in which they did not demonstrate competencies or knowledge in practice. Recruitment practices and interview scoring must be reviewed by the registered proprietor. While all references reviewed were verified, at least four staff had received references from peers/ colleagues they worked with previously, rather than from a person with line management responsibility. This is not this is not in keeping with the department of health circular on vetting and recruitment, 1994. Staff contracts were not provided to inspectors despite requests for these. Appropriate staff information was not held on staff personnel files and some files reviewed did not contain verification of qualifications as required.

Inspectors found that a deputy manager was appointed in a full-time capacity following interview in March 2021. Inspectors found this person did not hold the experience commensurate with the duties of the role. This person had qualified in social care in June 2020 and this was their first post in children's residential care.

Inspectors found that this person should not have been appointed to a position of management and given extra responsibilities. Inspectors saw no evidence that the deputy manager had received induction or training into the role, that they had been appropriately mentored or received professional quality supervision. They had no contract for this position and as mentioned previously there were inadequate policies and systems of governance in place to support their practice.

Upon application for registration in 2020 information was provided to the alternative care inspection and monitoring service outlining the staff complement. The centre was subsequently registered to operate with a centre manager, deputy social care manager, and eight social care staff all working 37.5 hours per week.

Inspectors reviewed rosters for this centre for the period 01/01/21 – 31/08/21 and found a number of practices of immediate concern. Inspectors observed that staff had worked back-to-back shifts on 127 occasions in this eight-month period. This is not safe, and the practice of back-to-back shifts must cease immediately. Shifts were also grouped together meaning that there were periods where staff worked up to 100 hours with limited or no time off from the centre and the roster was not organised to provide sufficient rest periods. The following was noted from the rosters provided:

- In August 2021 the appointed deputy manager worked for 9 consecutive days with no day off for a total of 98 hours during this period.
- Further, this deputy manager also worked a separate period of 98 hours over 11 days with only one day off in that 11-day period.
- In July 2021 a staff member worked 91 hours in 8 days with only one day off in this period of 8 days.
- In July 2021 a staff member worked 99 hours in 9 days with 2 days off in this period of 9 days.
- In July 2021 a staff member worked 75 hours in 7 days.
- In June 2021 a staff member worked 100 hours in 10 days.
- In June 2021 another staff member worked 99 hours in 9 days.
- Further, in June 2021 a staff member worked 105 hours over a 10-day period with only 2 days off in that 10 day period.

During the last inspection back-to-back shifts were explained to inspectors as being utilised in the context of Covid 19 risk management. During this inspection it was explained now in terms of staff preferring to work double shifts and also continuity for the young person. This is not in line with best practice and safeguarding issues may arise. Also on occasion, these staff were required to wake at 4am to drive the young person four hours to their activities/employment and return later. As previously stated, there is no evidence that this was considered by organisational management in terms of risk or health and safety.

Inspectors found from a review of rosters that three of the staff were not working full time hours despite being listed on the information provided for inspection as full time staff.

Inspectors found that on 94 days between January and August 2021 that only one social care worker was rostered to work during the day. The proprietor explained that a member of the management team was at times considered a second person cover despite the requirement for a second social care worker to be rostered. Inspectors noted that on 79 of these 94 days a person who was employed as an outdoor pursuits instructor was used as second person cover. This person does not hold a qualification in social care or related field, was not part of the social care staff in the centre and was not employed as a social care worker. This person should not have been used as second person cover. Inspectors found that this practice was unsafe and double cover rostering should have been provided at all times during this period. Further, an unqualified person who is not part of the social care team, the manager or deputy manager cannot be utilised as the second person on shift.

Inspectors found that the daily logs and handover records did not provide accurate information in respect of who was in the centre at any time. All staff were recorded at the top of the handover sheet despite some staff not coming on shift until 6pm. The daily logbooks did not record the times that staff were present.

There were two dedicated relief staff to cover annual or other types of leave. During interviews with staff members, inspectors found that staff demonstrated they had insight into the needs of the young person and skills to respond to them however, they were not guided by up-to-date relevant policies and procedures.

There were some measures in place to ensure staff retention. These included training, employee assistance and the director was looking into a pension contribution scheme at the time of inspection.

There was a formalised procedure for on-call arrangements at evenings and weekends. There was no record of the calls made to the person on call or the advice or direction given.

Given the issues that have been raised in this report in relation to vetting, interview practices, appointments of staff and rostering practices inspectors have concerns about operation of this centre. Inspectors found that this centre did not meet the requirements of the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7: Staffing.

Compliance with regulations	
Regulation met	**None identified**
Regulation not met	**Regulation 6** **Regulation 7**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- The registered provider must ensure that the centre maintains the staffing complement that it was registered for.
- The registered provider must ensure that personnel files contain a copy of signed contracts.
- The registered provider must ensure that appropriate references are in place for all staff and that qualifications are verified.
- The registered provider must ensure that staff have the appropriate skills, experience and competencies for the posts for which they are employed.
- The registered provider must ensure that staff receive appropriate induction and training for their posts.
- The registered provider must ensure that staff receive quality professional supervision to ensure a culture of learning, quality and safety.
- The registered provider must ensure that no unqualified staff that are not part of the social care complement work in place of social care workers.

- The registered provider must ensure that practice of working back-to-back shifts ceases.
- The registered provider must ensure there are accurate records of who is working in the centre and who attends handover meetings.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
2	The registered provider must ensure that the key working role is clearly defined and communicated to staff.	The management team have devised and developed a training tool for the keyworker role (Please see attached). Current keyworkers will receive this training and ongoing support through formal and informal supervision on the roles and responsibilities of the keyworker (Training tool to be completed by 31.10.21 and supervision ongoing). Moving forward management will review and evaluate all completed key work.	Moving forward, this keywork training tool will be utilised before staff develop into the keyworker role. The training tool will also be incorporated into all future staff inductions. Management have implemented a daily keywork learning review which will provide a framework for reviewing the factual accuracy of the content, evaluating if the placement plan objectives have been met, and identify areas of development.
	The registered provider must ensure that actions arising from discussions relating to placement planning in team meetings and supervision are clearly recorded and tracked.	The organisations proforma for team meetings and supervision meetings has been amended to detail actions arising from discussions relation to placement planning and behaviour support strategies	The centre managerial team will ensure all agreed actions are completed in line with oversight requirements. The proforma templates will ensure that all discussions and agreed actions are recorded. Moving forward, the National Standards will be

		(see forms attached). Completed on 19.10.21.	incorporated into the monthly staff team meetings where one staff member will present on one standard per month.
	The registered provider must ensure adequate recording and follow up to incidents when these occur.	All centre staff will receive formal training on recording and report writing in social care (To be complete by 31.12.21). Structural amendments to the handover book and the daily log will ensure all recordings and incidents are reviewed by the centres management team (completed 21.10.21 please see amended proforma attached).	The centre management team will review and evaluate all daily documentation. A quality assurance and governance officer has been appointed on the 01.11.21. The role will provide oversight and evaluation of recordings and incidents.
5	The registered provider must ensure that there are oversight and governance systems in place to ensure the centre is operating in compliance with the regulations and the national standards.	A new centre manager has been appointed and will begin the role in 02.11.21 with a transition period of one month. quality assurance and governance officer appointed on the 01.11.21. These roles will initially focus on completing an evaluation of inspection findings and compliance with the National Standards.	The senior management team's role includes oversight and governance of all the organisations services and oversees and governs all policy documents. The annual review of policies and procedures calendar will be included on the Centre – National Standards for Children's Residential Centres, 2018 (HIQA) compliance audit, which will be

			completed by the quality assurance and governance officer. The quality assurance and governance officer will also complete the national standards audit for Children's Residential Centres, 2018 (HIQA).
	The registered provider must ensure that all policies and procedures are up to date and relevant to legislation and national standards.	The organisation's policies and procedures are currently under review and will be amended to reflect the required standards and other relevant legislation (To be completed by 01.12.21). The director of services, centre manager, deputy manager and two suitably qualified and experienced staff members will comprise the panel tasked with completing the annual review of policies and procedures.	The Director of Services and Senior Management will design a checklist to be utilised to ensure all policy documents are relevant and reviewed regularly in line with National Standards 2018 (HIQA).
	The registered provider must ensure that all staff are familiar with policies, procedures, legislation, and national standards.	All current staff have been made aware that as the policies and procedures document is being updated, one staff member per month will be appointed to work in conjunction with the deputy manager to review one policy and devise a PowerPoint presentation to be presented	The organisation's Induction Programme for newly appointed staff will be revised and updated to include fortnightly training on the (To begin for staff appointed after January 2022). The organisations will utilise formal supervision and team meetings to develop awareness of the

		to the staff team at monthly team meetings (Commencing on 01.11.21). An in-house training programme on the national standards for children's residential centres will commence from the 01.11.21.	national standards within the staff team. Supervision will record individual staff's knowledge and understanding of the National Standards.
	The registered provider must ensure that staff are subject to a probation period with formal review and sign off.	The organisation has developed a probationary review assessment policy, completed on 19.10.21. All staff are currently engaged in contract reviews, the policy will be used to underpin probationary periods moving forward (see attached).	The implementation of the probationary review assessment policy will ensure the probationary periods are completed and signed.
	The registered provider must ensure that fit for purpose audits take place to assess compliance with legislation and national standards.	The organisation has appointed a quality assurance and governance officer on the 01.11.21. The key responsibility of this role will be implementation of existing audits templates.	The director of services will review the centre audits monthly in conjunction with the quality assurance and governance officer.
	The registered provider must ensure that all action plans agreed from ACIMS inspection reports are implemented as a matter of priority.	The director of services, senior management team, centre manager and deputy manager, and the quality and assurance officer will review all corrective	This systemic process has been added to the standing agenda on the senior management team meetings.

		actions and preventative action plans and ensure all agreed actions are completed.	
	The registered provider must ensure that senior management meetings are recorded and there is evidence of robust governance of the centre.	The director of services will ensure that monthly senior management meetings are accurately recorded using a structured proforma. The team meeting chair, at each monthly meeting, will ensure that team meetings are accurately recorded to reflect issues discussed and decisions agreed, using the structured proforma (attached). These minutes will also be read and signed off by all attendees and relevant decisions will be communicated to the staff team. Effective immediately.	The quality assurance and governance officer will complete centre audits, and these will ensure that there is evidence of robust governance at the centre.
	The registered provider must ensure that training is provided in the risk management framework to ensure that all staff are competent and confident in its use.	All full-time staff are due to attend a risk management training day on the 20/11/2021. This will ensure staff are competent and confident in their application of risk assessment and management skills.	Risk management training will provide staff with the knowledge and skills to ensure competence in risk management and assessment.

	The registered provider must ensure that all records in the centre are accurate and correctly reflect staff actions.	All centre staff will receive formal training on recording and report writing in Social Care (To be complete by 31.12.21). Structural amendments to the Handover Book and the Daily log will ensure all recordings and incidents are reviewed by the centres management team (completed 21.10.21).	The centre management team and quality and assurance officer appointed on the 01.11.21. This role will provide oversight and evaluation of recordings and incidents.
	The registered provider must ensure that the support provided to the young person by a previous manager of the service is structured and agreed with SW, Tusla.	The previous centre manager has clarified their role with the young person's aftercare team, and they have approved this continued involvement (see attached correspondence from aftercare team).	Not applicable.
	The registered provider must ensure that all corporate and centre risks are recorded on risk registers, that mitigation strategies are in place and that risks are monitored on an on-going basis.	The organisations corporate risk register will be reviewed bi-monthly by the senior management team. Effective Immediately.	This systemic process has been added to the standing agenda on the senior management team Meetings.

	The registered provider must ensure that there is a record of all tasks delegated to appropriately qualified staff members as well as a record of key decisions.	The organisations delegation record structure has been amended and updated to include a record of key decisions made in relation to delegated duties in line with the national standards requirements. In a similar vein, a delegation of responsibility log has been adapted to include same which will be appropriately stored in the individual staff members supervision file.	The organisations director of services and the monitoring and inspection service will be informed of any amendment or delegation of the manager's role. The organisations director of services will review and provide final approval, or otherwise, of any extended period (more than one month) whereby the centre manager delegates any or all of their duties to an appropriately qualified member of staff.
6.	The registered provider must ensure that the centre maintains the staffing complement that it was registered for.	Recruitment initiatives have been completed. A new centre manager has been appointed (Start date, 02.11.21). A quality assurance and governance officer has also been appointed as of the 01.11.21. In addition, two new full time social care workers have been appointed, commencing from the 01.11.21. Ongoing recruitment measures have been implemented in the form of advertisements on relevant websites.	The senior management team have developed robust organisational development strategies. These will ensure that the financial integrity of the organisation is secure moving forward.

	The registered provider must ensure that personnel files contain a copy of signed contracts.	New employment contracts have been issued to all staff. The centre's management team are engaging with all staff to clarify terms and conditions and gain consent to transition into the new full-time contracts.	Moving forward, the new employment contracts will be reviewed and signed prior to employment commencing.
	The registered provider must ensure that appropriate references are in place for all staff and that qualifications are verified.	Affected staff have been made aware of the issue in terms of appropriate references. The centre management team are currently engaged in addressing the issue with individual staff. This will be completed by 30.11.21.	The organisations application forms have been adapted to outline the appropriate requirement in terms of references.
	The registered provider must ensure that staff have the appropriate skills, experience, and competencies for the posts for which they are employed.	The centre management team has been restructured. A new centre manager has been appointed (Start date, 02.11.21) with the relevant experience as outlined in staffing memo February 2020. The deputy manager has been moved to an acting position and the new centre manager will begin a mentoring/supervisory role once they commence employment.	Criteria for all positions within the organisation have been included in job descriptions. A recruitment checklist is currently in development in association with the organisations HR support team. The checklist will be utilised during the interview process to ensure compliance with the national standards.

	The registered provider must ensure that staff receive appropriate induction and training for their posts	The organisation is developing a new Induction programme for current and new staff. This will be completed by 30.11.21.	new staff will receive a comprehensive induction programme.
	The registered provider must ensure that staff receive quality professional supervision to ensure a culture of learning, quality and safety.	The organisations senior management team are reviewing the internal supervision process. A new format for supervision has been designed. The quality assurance and governance officer has been assigned the task of reviewing all aspects of the personnel function and training needs.	The quality assurance and governance officer in association with centre management will complete regular audits of personnel files and supervision recordings.
	The registered provider must ensure that no unqualified staff that are not part of the social care complement work in place of social care workers.	The recruitment initiative outlined above has brought the staffing complement in line with the requirements.	Ongoing recruitment initiatives will ensure the centre has a full complement of social care workers in place.
	The registered provider must ensure that practice of working back-to-back shifts ceases.	The organisation senior management and HR teams have reviewed the organisations shift pattern. Double shifts have ceased, and the management teams have engaged with staff effected.	Not applicable.

	The registered provider must ensure there are accurate records of who is working in the centre and who attends handover meetings	The centre management team have amended the relevant documentation to ensure there is an accurate recording of who attends handover meetings.	The new format of the handover documents will effectively reflect who is working in the centre and who attends handover meetings. a staff signing in and out book has also been introduced to the centre which will ensure there is an accurate record of who is working in the centre on any given date.